Feasibility of a Pilot Project Using Ryan White Health Insurance Funding to Assist Consumers Below 100% FPL with Purchasing Health Insurance

A Special Study of the Houston Area Ryan White Planning Council
Approved XX XX, 201X

Acknowledgments

The Houston Area HIV Services Ryan White Planning Council would like to thank the following individuals and agencies for their contribution to this Special Study.

Comprehensive HIV Planning Committee Members

Ted Artiaga
Patient Navigator, Legacy Community Health Services
Curtis Bellard
Former Security Operations Manager, Omni Hotels
David Benson
Director of Programs & Special Programs, Harris County Precinct One
Evelio Salinas Escamilla
Research Administrator University of Houston School of Social Work; and Co-Chair, Comprehensive HIV Planning Committee
Herman Finley
Health Education Risk Reduction Coordinator, St. Hope Foundation, Inc.; and Vice-Chair, Houston Area HIV Services Ryan White Planning Council
Morenike Giwa
Founder, Advocacy without Borders
Tam Kiehnhoff
Former Case Management Coordinator, Triangle Area Network
John Lazo
Producer, Standing Room Only Productions
Osaro Mgbere, PhD
Epidemiologist, Houston Department of Health and Human Services
Nancy Miertschin
HIV Projects Manager, Thomas Street Health Center; and Co-Chair, Comprehensive HIV Planning Committee
Allen Murray
External Member, Comprehensive HIV Planning Committee
Shital Patel, MD
Assistant Professor, Baylor College of Medicine
L. Bunny Woods
Counseling, Testing, and Referral Coordinator, St. Hope Foundation
Amana Turner
Program Coordinator, Change Happens

Staff

Ryan White Planning Council
Office of Support
Tori Williams
Amber Alvarez
Diane Beck
Georgette L. Monaghan

Key Informants

Katy Caldwell
Executive Director, Legacy Community Health Services
Orlando Dawson
Nurse, St. Hope Foundation
Joseph Fuentes, Jr.
CEO, Houston Area Community Services, Inc.
Melisa Garcia
Vice President of Clinical Business Services, Legacy Community Health Services
Sandra Longoria
Director of Financial Services, Legacy Community Health Services
Kenneth Malone
HIV Project Analyst, HIV Services Administration, Thomas Street Health Center
Jack Parker
Vice President of Pharmacy Operations, Legacy Community Health Services
Ann Robbins, PhD
Senior Public Health Advisor, TB/ HIV/STD Unit, Texas Department of State Health Services
Shannon Schrader, MD
Concierge Physician, MDVIP; and Volunteer Physician, Legacy Community Health Services
Janina Vazquez
Manager, HIV Care Services Group, Texas Department of State Health Services

Funding acknowledgment:

The development of this document was made possible by funding from the Ryan White HIV/AIDS Treatment Extension Act of 2009.

No incentives were provided for this study.

Background

The Houston Area Ryan White Planning Council (RWPC) is a volunteer planning group comprised of 38 appointed community members charged with planning, designing, and allocating funding for HIV medical care and support services for people living with HIV/AIDS in the six-county Houston Eligible Metropolitan Area (EMA). To inform these processes, the RWPC conducts a community needs assessment every three years that measures and describes the HIV medical care and support service needs of the local HIV-positive community. In addition to capturing data related to service needs and barriers, the 2014 Houston Area HIV/AIDS Needs Assessment serves as a tool to evaluate consumer knowledge about services, engagement along the HIV Care Continuum (including a profile of those with unmet need), and co-occurring medical conditions and social determinants of health.

The RWPC's Comprehensive HIV Planning Committee commissions Special Studies to complement and contextualize the wealth of information gathered through the community needs assessment process, and to bridge the gap in data between community needs assessments. Past Special Studies have examined service needs among special demographic populations such as people living with HIV/AIDS in the Houston EMA who are transgender/gender non-conforming, youth, or incarcerated/recently released. Following the first Affordable Care Act Health Insurance Marketplace Open Enrollment period, the Comprehensive HIV Planning Committee directed the RWPC Office of Support to conduct two Special Studies in 2014 pertaining to health insurance. This report details the key findings from the Special Study "Feasibility of a Pilot Project Using Ryan White Health Insurance Funding to Assist Consumers Below 100% FPL with Purchasing Health Insurance."

Introduction

The Patient Protection and Affordable Care Act (ACA) brought about extensive changes for uninsured and under-insured people living with HIV/AIDS (PLWHA). Guaranteed issue prevented insurers from denying coverage for people with a pre-existing condition like HIV. Community rating prohibited insurers from charging people with pre-existing conditions more for health coverage. The ACA also eliminated lifetime and annual coverage limits on essential health benefits. More recent changes like the Health Insurance Marketplace and Medicaid expansion have altered the PLWHA in many states access health care.

State health insurance exchanges and the federal Health Insurance Marketplace provide locations for people to shop for qualified health plans (QHPs) that meet their needs and budgets. People with annual incomes between 100% and 400% of the Federal Poverty Level (FPL) who have no existing coverage can qualify for an advance premium tax credit (subsidy) to help cover their monthly insurance premium payments. In states that have chosen to expand their Medicaid programs, people with annual incomes at 133% and below are now eligible to apply for Medicaid coverage. However, in states that have not expanded their Medicaid programs, uninsured individuals with incomes too low to qualify for subsidies to purchase Health Insurance Marketplace QHPs and who do not meet other eligibility requirements for Medicaid have limited options for obtaining health coverage. In Texas, an estimated 948,000 individuals (including PLWHA) fall into this Medicaid coverage gap, and Ryan White programs throughout the state

often provide care and support services to PLWHA in the Medicaid coverage gap as the payer of last resort.[1]

Between March 2013 and February 2014, nearly 70% of Ryan White consumers in the Houston Area had annual incomes below 100% FPL.[2] Of these consumers, only 32% had health coverage. This means that 5,562 local Ryan White consumers (48% of all local Ryan White consumers) were uninsured, and not eligible for a Health Insurance Marketplace subsidy due to low income. In addition to relying on Ryan White funded care and support services to treat their HIV, these consumers have limited access to medical care for other co-occurring conditions. Amid questions of whether the Texas HIV Medication Program (THMP), the AIDS Drug Assistance Program (ADAP) for the state of Texas, would offer reimbursement to local programs for purchasing QHPs for uninsured consumers below 100% FPL, this Special Study was commissioned to evaluate whether a pilot project to purchase Health Insurance Marketplace QHPs and cover cost-sharing expenses such as co-pays, co-insurance and deductibles for 100 uninsured consumers below 100% FPL for one year would be feasible and cost-effective.

Methodology

Unlike past studies, this Special Study did not include client-level data collection. The feasibility of the proposed pilot project was evaluated using a brief literature review, semi-structured key informant interviews with 10 stakeholders conducted in October 2014, and cost analyses using unsubsidized 2015 Marketplace Silver plans accessed through the federal Health Insurance Marketplace website to populate a feasibility framework.[3] The TELOS feasibility framework was used to develop key informant interview questions, and to categorize findings into specific domains. The acronym TELOS describes Technical/Technological, Economic, Legal, Operational, and Schedule considerations for project feasibility. To determine likelihood that the proposed pilot project will result in cost-neutrality or cost-savings, greater emphasis has been placed on assessing economic feasibility.

Limitations

In general, feasibility studies are not intended to determine whether a particular program or project should be implemented, or forecast program or project outputs and outcomes. The function of feasibility studies is to inform the decision-making and planning processes through describing the components that must be present to initiate and complete a proposed program or project. As such, this Special Study is only one of many tools to be used in determining whether and how the proposed pilot project should be implemented.

Though the cost analyses presented in this report were conducted across four distinct QHPs, the cost variability between plans and consumers is another limitation of this Study. For example, premium and cost-sharing assistance within the same QHP can vary greatly depending on the formulary tiers of the consumer's medications. The actual cost of the pilot could vary considerably, which accounts for the wide cumulative estimated cost range for the pilot provided in the findings of this report.

Finally, the impact of ADAP was not included in the calculations of the local Ryan White program costs for covered service categories, the estimated cost of the pilot per consumer, and for the project as a whole. In the event that ADAP offers reimbursement to local programs for premium and cost-sharing assistance for unsubsidized Health Insurance Marketplace QHPs future, the total cost of the pilot project would be substantially reduced. At the time of this report was created, ADAP has not offered reimbursement to local programs for premium and cost-sharing assistance for Health Insurance Marketplace QHPs.

Findings

Technical/Technological Feasibility

No technical/technological barriers to pilot project implementation were found in the Study. A benefit to the current activities of Ryan White-funded providers to assist subsidy-eligible consumers with purchasing and sustaining health insurance is that no additional technical/technological infrastructure or resources would be required to implement the proposed pilot project. Computers with reliable internet access and phone lines are already available and used to assist consumers with the enrollment process. Moreover, current software used for billing and statement processing can be applied to premium and cost-sharing assistance for consumers with unsubsidized Health Insurance Marketplace QHPs.

Economic Feasibility

Many factors were considered in evaluating the economic feasibility of the pilot project, including current costs to the local Ryan White program for covered services, premium and cost-sharing assistance estimates for individual participants across a variety of QHPs, estimated cumulative premium and cost-sharing assistance for the pilot, considerations for funding the administrative processes of the pilot project, and project sustainability.

Under the ACA, all Health Insurance Marketplace QHPs must provide coverage for essential health benefits, which include "ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care."[4] To evaluate the potential for cost-neutrality or cost-savings as a result of the pilot project, the average cost per unduplicated client (UDC) for covered services in the local Ryan White program were calculated in Table 1. These costs include services funded under Ryan White Parts A and B, MAI, and State Services, and exclude ADAP (See Limitations).

Table 1: Ryan White Program Average Costs per UDC by Covered Service Category in 2013[2]

Primary Care	$1,176
Local Pharmacy Assistance Program (LPAP)	$722
Medical Nutrition Therapy (supplements)	$582
Mental Health Therapy and Counseling	$803
Substance Abuse Treatment (outpatient)	$2,179
Total average cost per UDC for all covered services	**$5,462**

The total average cost per UDC to the local Ryan White program in 2013 for services that would be covered as essential health benefits under Health Insurance Marketplace QHPs was $5,462. It is important to note that actual cost and service utilization for individual consumers varied in relation to the needs of the consumer.

Two key informants interviewed for this Study estimated the total premium and cost-sharing assistance for a consumer below 100% FPL to range between $10,000 and $11,000 annually for unsubsidized 2014 Health Insurance Marketplace QHPs. To assess estimated costs using 2015 QHPs available locally, cost analyses were conducted for four unsubsidized QHPs available in the Houston area. According to the Texas Department of State Health Services, the greatest proportion of PLWHA in the Houston EMA in 2013 were male and between the ages of 45 and 54, and it is estimated that between 50% and 70% of PLWHA smoke.[5, 6] For these reasons, premium and cost-sharing assistance estimates for the QHPs evaluated in this Study were calculated using cases in which the pilot participant was a 54 year-old male smoker who required either a low tier or a high tier medication. Unsubsidized Health Insurance Marketplace QHPs compared in this Study were categorized as High/Low Premium and High/Low Medication Co-Pay or Co-insurance. (For the full comparison of unsubsidized Health Insurance Marketplace QHPs evaluated in this Study, see Appendix.)

The total annual premium and cost-sharing assistance amount per participant was calculated for: 12 months of premium payments, four infectious disease specialist visits, 4 lab tests, and 12 months of medications. Comparisons were also made for high and low tier medications according to each plan's formulary. Excluding multiple medications and non-HIV related care, the estimated total annual premium and cost-sharing amount per participant ranged between $6,636 and $15,134. Health Insurance Marketplace health maintenance organization (HMO) QHPs tended to have lower premiums and lower total annual costs, even for cases in which the participant required a higher tier medication. The formularies for these QHPs listed most commonly prescribed antiretroviral (ARV) medications, including single-tab regimens, as mid-tier or low tier. However, the HMO QHPs examined greatly restricted the number of in-network infectious disease specialists that would be accessible to the pilot participants. For example, participants receiving assistance with purchasing the lower cost HMO QHPs would not be able to access providers through Harris Health System, including providers at Thomas Street Health Center.

Plans with higher premiums with both low and high medication co-pays/co-insurance were also examined. These QHPS tended to be preferred provider organization (PPO) plans, which would allow the pilot participant to access a larger network of infectious disease specialists. However, the PPO plans examined also had much higher premium payments, and one listed most commonly prescribed ARV medications as specialty tier, which require a very high co-insurance of 40%. The PPO QHP with the highest premium examined also had the lowest out-of-pocket limit, which included the prescription drug out-of-pocket limit.

Based on the estimated total annual premium and cost-sharing assistance cost per participant, the cumulative estimated cost for the pilot to provide premium and cost-sharing assistance to 100 consumers by purchasing and sustaining unsubsidized Health Insurance Marketplace QHPs could range between $663,600 and $1,513,400 for one year. Excluding ADAP, the cumulative cost to the local Ryan White program to provide similar services covered under the plans would be $546,200 or lower, depending on service utilization. It is important to note that participants with unsubsidized Health Insurance Marketplace QHPs could access care for medical concerns beyond HIV care. Considering the cost of uncompensated care and avoidable hospitalization, there may be cost-neutrality or cost-savings outside the local Ryan White program for pilot participants. Further study is necessary to determine whether local partnerships with facilities that would benefit from reduced uncompensated care and avoidable hospitalization costs, including partnerships with facilities receiving funding through the 1115 Waiver Texas Healthcare Transformation and Quality Improvement Program, would result in lower costs for the pilot project through cost-sharing.

In addition to the estimated cumulative annual premium and cost-sharing assistance cost for the pilot project, funding for administrative processes may be required. In the event that the pilot is scheduled to begin during an Open Enrollment period, additional personnel may be required to assist the 100 pilot participants with Health Insurance Marketplace enrollment. Funding for personnel to communicate with participants, process statements, and issue payments would also be needed to carry out the pilot project may be difficult to obtain, as restrictions may prevent the use of Ryan White funds for "any administrative costs outside of the premium payment of the health plans."[7]

The final consideration for economic feasibility is project sustainability. The function of the proposed pilot project is to determine whether providing premium and cost-sharing assistance for unsubsidized Health Insurance Marketplace plans to consumers below 100% FPL provides enough cost-neutrality or cost-savings and benefit to the consumers to warrant program-wide implementation. Should the outcomes of the pilot project indicate that program-wide implementation is not beneficial, pilot participants would experience a loss of health coverage at the conclusion of the project (see Legal Feasibility). If project outcomes indicate program-wide implementation would be beneficial, the present level of funding is unlikely to accommodate premium and cost-sharing assistance to the over 5,500 local consumers who potentially fall in the "Medicaid gap".

Legal Feasibility

The Study found no legal or policy barriers to implementation of the pilot project. Policy guidance from Health Resource Service Administration's (HRSA) HIV/AIDS Bureau (HAB) supports the use of Ryan White funding for premium and cost-sharing assistance for individuals who are ineligible for subsidy when doing so would be cost-effective. According to a HAB Policy Clarification Notice released in 2013 and revised in 2014:

> If resources are available, [Ryan White HIV/AIDS Program (RWHAP)] grantees and subgrantees are strongly encouraged to use RWHAP funds for premium and cost-sharing assistance for [clients not eligible for premium tax credits and cost-sharing reductions in a Health Insurance Marketplace] when it is cost-effective, as appropriate. The grantee and subgrantee must ensure that use of RWHAP funds for premium and cost-sharing assistance for these clients is cost-effective.[7]

Though there are no legal or policy barriers to implementation of the pilot project, consideration must be made to ensure informed consent is obtained from participants before acceptance into the pilot. In the event that the pilot project is not cost-effective, pilot participants would lose health coverage at the conclusion of the project. While this may have a minimal impact for participants' HIV care among participants that retain their providers when beginning their Health Insurance Marketplace QHPs, loss of coverage may present a substantial barrier to accessing providers for non-HIV related medical conditions.

Operational Feasibility

Certified Application Counselors at Ryan White funded sites currently assist subsidy-eligible consumers with enrollment in the Health Insurance Marketplace. While the process of assisting 100 consumers below 100% FPL with enrollment would not differ from the current method, an additional Certified Application Counselor could be required to assist with enrollment if the pilot project takes place during an Open Enrollment period (see Schedule Feasibility).

Additional administrative needs for premium and cost-sharing assistance processing may present a challenge to implementing the pilot project. Personnel would be needed for communication with pilot participants, receiving and processing statements, and issuing payments to insurers. One key informant that currently issues premium payments to insurers noted that the current process entails issuing individual payments for each consumer because most insurers will not accept mass third-party payments. Funding may not be available to provide additional administrative personnel (see Economic Feasibility).

Schedule Feasibility

While this Study yielded no barriers to schedule feasibility, there were certain aspects of scheduling the pilot project's implementation and funding that require consideration. As purchase of Health Insurance Marketplace QHPs can only occur during an Open Enrollment period, the pilot project would need to be scheduled to begin during an Open Enrollment period, or be limited to consumers with life-changing events that qualify the participants for a Special Enrollment Period, such as loss of health coverage, marriage or divorce, birth or adoption, a

death in the household, change in income, moving outside the current plan's coverage area, gaining citizenship, or release from incarceration. If the pilot is scheduled to begin during an Open Enrollment period, funding for the project could span multiple fiscal years, and the earliest opportunity to begin the pilot project would be the Health Insurance Marketplace Open Enrollment period for coverage beginning in 2016. The pilot would also require sufficient funding to cover high deductible cost-sharing assistance during the first quarter of the calendar year.

Alternate Pilot Project

Though barriers to technical/technological, legal, operational, and schedule feasibility discovered in the course of this Study are minimal, substantial barriers to the economic feasibility of the pilot project may prevent implementation of the pilot project unless some amount of cost-sharing is obtained through a partnership or ADAP reimbursement. However, an unanticipated finding of this Study is that purchasing add-on dental plans for consumers already enrolled in subsidized Health Insurance Marketplace QHPs may result in cost-savings for the local Ryan White program in Oral Health services, clear system capacity, and expand consumer accessibility to a larger network of dental providers.

In 2013, the local Ryan White program average cost per UDC for Oral Health services was $604. A query of subsidized Health Insurance Marketplace plans for a 54 year-old male who smokes yielded 30 available add-on dental plans with monthly premiums ranging from $9 to $51. A brief cost analysis was conducted for a high coverage dental HMO with a $15 monthly premium.

Plan: Alpha Dental Individual & Family DeltaCare® USA Preferred Plan for Families Dental HMO
Monthly Premium: $15 x 12 payments → $180
Deductible: $0
Out of Pocket Maximum: None for adults age 19 and over
2 annual cleanings ($5 Office Visit Co-Pay; $5 Prophylaxis (Cleaning) Co-Pay): $10 x 2 cleanings → $20
Annual X-rays ($5 Panoramic X-ray (Every 2-5 Years); No Cost for Bitewing X-rays): $5 x 1 X-ray → $5
3 Amalgam Fillings: $25/1 Surface; $30/2 Surface; $40/3 Surface x 3 Fillings + $5 Office Visit → $80-$125
1 Extraction ($18): $18 + $5 Office Visit →$23
Total Cost: $308 -$353

Though the proposed alternate pilot project would not address access to health coverage for consumers in the "Medicaid gap", purchasing add-on dental plans for consumers enrolled in subsidized Health Insurance Marketplace QHPs could provide cost-savings and added benefits for consumers. Further study is needed to develop a more detailed estimate of potential cost-savings, identify plans that cover commonly utilized dental services within the Oral Health service category and have Ryan White-funded providers in-network , and assess whether providers in the community that are not funded through the local Ryan White program could adequately address the unique dental care needs of PLWHA.

References

1. Garfield, R et al., "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update", The Henry J. Kaiser Family Foundation, (November 12, 2014) http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/
2. Ryan White Grant Administration and The HIV Resource Group, "FY15 How to Best Meet the Need Service Utilization Presentation", (Presented April 7, 2014)
3. http://www.healthcare.gov/see-plans
4. https://www.healthcare.gov/glossary/essential-health-benefits/
5. Texas Department of State Health Services HIV/STD Prevention and Care Branch, Planning and Program Evaluation Group Data Team, "HIV Prevalence 2004-2013", (Received July 31, 2014)
6. U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Rockville, MD: U.S. Department of Health and Human Services, (2014) http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf
7. HRSA/HAB, "Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance Policy Clarification Notice (PCN) #13-05", (Revised June 6, 2014) http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf

Appendix

Annual Total Premium and Cost-Sharing Assistance Estimate							
Plan 1: Molina Marketplace · Molina Marketplace Silver 250 Plan HMO Low premium, high medication co-pay/co-insurance		**Plan 2: Blue Cross and Blue Shield of Texas · Blue Advantage Silver HMO℠ 004** Low premium, low medication co-pay/ co-insurance		**Plan 3: Cigna Healthcare · myCigna Copay Assure Silver Plan** High premium, high medication co-pay/co-insurance		**Plan 4: Assurant Health · Assurant Health Silver Plan 001** High premium, low medication co-pay/co-insurance	
Monthly Premium: $453 x 12 payments → **$5,436**		Monthly Premium: $575 x 12 payments → **$6,900**		Monthly Premium: $732 x 12 payments → **$8,784**		Monthly Premium: $866 x 12 payments → **$10,392**	
Deductible: **$0**		Deductible: **$3,000**		Deductible: **$0**		Deductible: **$3,500**	
OOP* Maximum: **$6,600**		OOP* Maximum: **$6,350**		OOP* Maximum: **$6,350**		OOP* Maximum: **$3,500**	
4 ID Specialist Co-Pays: $75 x 4 visits → **$300**		4 ID Specialist Co-Pays: $50 x 4 visits → **$200**		4 ID Specialist Co-Pays: $75 x 4 visits → **$300**		4 ID Specialist Co-Pays: **N/A**	
4 Lab Co-Pays ($30): $30 x 4 labs → **$120**		4 Lab Co-Insurance (20%): $200 x 4 labs at 20% → **$160**		4 Lab Co-Insurance (40%): $200 x 4 labs at 40% → **$320**		4 Lab Co-Pays: **N/A**	
Low Tier Medication (Atripla) ($65): $65 x 12 months → **$780**	High Tier Medication: (Intelence)(40%): $1,020 x 12 months at 40% → **$4,896**	Low Tier Medication (Stribild) ($50): $50 x 12 months → **$600**	High Tier Medication (Fuzeon)($150): $150 x 12 months → **$1,800**	Low Tier Medication ($25): **N/A**	High Tier Medication (Atripla)(40%): $1,800 x 12 months at 50% →**$8,640**	Low Tier Medication: **N/A**	High Tier Medication: **N/A**
Total Cost: $6,636	**Total Cost: $10,752**	**Total Cost: $7,860**	**Total Cost: $9,060**	**Total Cost: N/A**	**Total Cost: $15,134**	**Total Cost: $13,892**	**Total Cost: $13,892**
Notes: Prescription drug OOP maximum included in OOP maximum; limited provider network with HMO (ex: participant would not be able to see a provider at Thomas Street Health Center); most commonly prescribed ARVs are mid-tier or lower		Prescription drug OOP maximum included in OOP maximum; limited provider network with HMO (ex: participant would not be able to see a provider at Thomas Street Health Center); most commonly prescribed ARVs are mid-tier or lower		Prescription drug OOP maximum included in OOP maximum; all commonly prescribed ARVs specialty tier medications according to plan formulary		No charge on medications, PCP/Specialist visits, or labs after deductible is met; prescription drug OOP maximum included in OOP maximum; formulary covers most ARVs.	

* Annual Out of Pocket Maximum